Coding and Billing Guidelines: Helicobacter Pylori Testing

Effective Date
10/16/2009

Revision Effective Date
NA

Article Text
This article contains the coding guidelines and reasons for denial for Helicobacter Pylori Testing. This article should be used in combination with LCD Helicobacter Pylori Testing (PATH-026).

General Guidelines for Submitting Claims for Carriers or Intermediaries or MAC Part A or Part B:
Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be printed on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Coding Guidelines Part A

1. ICD-9 codes must be reported to the highest level of specificity for the date of service.
2. Screening tests, in the absence of signs and symptoms of illness should be billed with "V" codes for a screening denial.
3. C-13 or C-14 Breath Tests (78267, 78268, 83013, and 83014) should be billed as follows;
   Clinical Laboratory
   a. 83013 (C-13) should be billed for the analysis of the breath sample by mass spectrometry, and includes the drug/agent and kit/supplies.
   b. 83014 (C-13) should be billed for the administration of the drug/agent and collection of breath sample.
   Nuclear Medicine
   a. 78267 (C-14) should be billed for the acquisition of the breath sample.
   b. 78268 (C-14) should be billed for the urea breath test analysis.
4. Microwell based enzyme immunoassay
   a. 87338 Requires a diagnostic code(s) that indicates the need for the test.
   b. 87339 Excludes H. pylori breath and blood by mass spectrometry and liquid scintillation

5. When billing for services in a non-covered situation (e.g., does not meet indications of the related LCD), use the appropriate modifier. To bill the patient for services that are not covered (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary Notice (ABN) be obtained before the service is rendered.
    a. GA: Waiver of Liability statement on file. Use for patients who do not meet the covered indications and limitations of the LCD and for who an ABN is on file. ABN does not have to be submitted but must be made available upon request.
    b. GZ: Waiver of liability statement on file. Use for patients who do not meet the covered indications and limitations of this LCD and who did **not** sign an ABN.
    c. GY: item or service is statutorily excluded or does not meet the definition of any Medicare benefit.

For OPPS claims HPCPS/CPT codes 78267 and 78268 must be billed with revenue codes 030X or 031X.

Coding Guidelines Part B

1. ICD-9 codes must be reported to the highest level of specificity for the date of service.
2. Screening tests, in the absence of signs and symptoms of illness should be billed with "V" codes for a screening denial.
3. C-13 or C-14 Breath Tests (78267, 78268, 83013, and 83014) should be billed as follows;
   Clinical Laboratory
    a. 83013 (C-13) should be billed for the analysis of the breath sample by mass spectrometry, and includes the drug/agent and kit/supplies.
    b. 83014 (C-13) should be billed for the administration of the drug/agent and collection of breath sample.

   Nuclear Medicine
    a. 78267 (C-14) should be billed for the acquisition of the breath sample.
    b. 78268 (C-14) should be billed for the urea breath test analysis.

Per the Medicare Physicians Fee Schedule Data Base, neither CPT 78267 nor CPT 78268 has any physician billable component.

4. Microwell based enzyme immunoassay
    c. 87338 Requires a diagnostic code(s) that indicates the need for the test.
    d. 87339 Exclude H. pylori breath and blood by mass spectrometry and liquid scintillation.
5. **Physician Billing:** Physicians may bill Medicare directly for the breath test even if the sample is returned to the manufacturer for analysis. Use CMS-1500 form with modifier 90 to indicate that the analysis was a purchased diagnostic test.
6. **Laboratory Billing:** A clinical laboratory Improvement Amendments (CLIA)-licensed, Medicare certified laboratory may also bill Medicare for the breath test analysis.
7. When billing for services in a non-covered situation (e.g., does not meet indications of the related LCD), use the appropriate modifier. To bill the patient for services that are not covered (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary Notice (ABN) be obtained before the service is rendered.
    a. GA: Waiver of Liability statement on file. Use for patients who do not meet the covered indications and limitations of the LCD and for who an ABN is on file. ABN does not have to be submitted but must be made available upon request.
    b. GZ: Waiver of liability statement on file. Use for patients who do not meet the covered indications and limitations of this LCD and who did **not** sign an ABN.
8. Type of Bill and Revenue Codes DO NOT apply to Part B.

CMS National Coverage Policy:
Title XVIII of the Social Security Act section 1862 (a) (1) (A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a) (7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Notes:
Italicized font - represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at http://www.cms/hhs.gov/coverage

Revision History Number/Explanation
01/14/2011, Annual review no change in coverage added effective date on Coding and billing guideline to match effective date of LCD.
11/19/2009: Added billable revenue code 031X for CPT codes 78267-78268 with effective date for claims processing of 09/16/2009. Providers notified via WPS policy update webpage and January 2010 eNews Listserv.